FILED JAN 22 1941

No. 2
11-10-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 44165

Registration District No. 875 Primary Registration District No. 6162 Registrar's No. 304

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County VERNON
(b) City or town NEVADA (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: STATE HOSPITAL NO 3 (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ____ In this community 15 DAYS. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County CHRISTIAN
(c) City or town OZARK (If outside city or town limits, write "RURAL")
(d) Street No. NOT KNOWN (If rural, give location)
(e) If foreign born, how long in U. S. A.? U.S.A years.

3. (a) PRINT FULL NAME MARY V. JONES

3. (b) If veteran, name war NO 3. (c) Social Security No. NONE

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced WIDOW

6. (b) Name of husband or wife WILLIAM JONES 6. (c) Age of husband or wife if alive DEAD. years

7. Birth date of deceased unknown (Month) unknown (Day) 1869 (Year)

8. AGE: Years 71 Months — Days — If less than one day — hr. — min.

9. Birthplace CLARK COUNTY (City, town, or county) MISSOURI (State or foreign country)

10. Usual occupation HOUSEWIFE

11. Industry or business NONE

FATHER
12. Name OSCAR PAKE
13. Birthplace UNKNOWN (City, town, or county) MISSOURI (State or foreign country)

MOTHER
14. Maiden name JOHANNA BYERS
15. Birthplace UNKNOWN (City, town, or county) MISSOURI (State or foreign country)

16. (a) Informant RECORDS STATE HOSPITAL #3
(b) Address NEVADA MISSOURI

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 19, 1940 (Month) (Day) (Year)
(c) Place: burial or cremation Kansas City, Mo.

18. (a) Signature of funeral director D. W. Newcomer's Sons
(b) Address Broad Creek & Paseo K. C. Mo

19. (a) 12-18-40 (Date received local registrar) (b) Allen A Hayes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month DEC. day 17 year 1940 hour 11 minute 10 P. M.

21. I hereby certify that I attended the deceased from DEC 2, 1940, to DEC 17, 1940, that I last saw her alive on DEC 17, 1940, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death HYPOSTATIC CONGESTION	48 Hrs
Due to CHRONIC MYOCARDITIS	
Due to	
Other conditions ARTERIOSCLEROSIS (Include pregnancy within 3 months of death) SENILITY INTERTROCHANTERIC FRACTURE OF RT HIP	
Major findings: Of operations NONE	
Of autopsy NONE	

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) FALL
(b) Date of occurrence DEC 6, 1940
(c) Where did injury occur? NEVADA (City or town) VERNON (County) MO. (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? FELL ON HOSPITAL WARD (Specify type of place)
While at work? NO (e) Means of injury FRACTURE RT HIP.

23. Signature Paul L. Barone (M. D. or other) MD
Address State Hosp No 3 Nevada Mo Date signed Dec 17

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 7,
District File Number 15-41-1dc 1-4
Date Filed 1-13-41

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.